3.1 Claim Billing

3.1.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using Provider Electronic Solutions (PES) software (provided by Electronic Data Systems (EDS) at no cost) or other Health Insurance Portability and Accountability Act (HIPAA) compliant vendor software.

- To submit electronic claims, use the HIPAA 837 Institutional transaction
- To submit claims on paper, use original red UB-04 claim forms available from local form suppliers

All claims must be received within one (1) year of the date of service.

3.1.2 Electronic Claims

For PES software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See *Section 2, General Billing Information* for more information on electronic billing.

3.1.2.1 Guidelines for Electronic Claims

Provider number
In compliance with HIPAA and the National Provider Identifier (NPI) initiative, Idaho Medicaid requires the submission of the NPI number on electronic 837 claim transactions. Idaho Medicaid recommends providers obtain an NPI for each individual Medicaid provider number. Electronic claims will not be denied if the electronic 837 Institutional transaction is submitted with the Idaho proprietary Medicaid provider number. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the 837 claim transaction.

Detail Lines
Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

Surgical Procedure Codes
Idaho Medicaid allows twenty-five (25) surgical procedure codes on an electronic HIPAA 837 Institutional claim.

Four Modifiers
On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code, up to four (4) modifiers are allowed. (On a paper claim, only two (2) modifiers are accepted.)

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

Type of Bill (TOB) Codes
Idaho Medicaid rejects all electronic transactions with Type of bill (TOB) codes ending in a value of six (6). Electronic HIPAA 837 Institutional claims

with valid TOB codes, not covered by Idaho Medicaid, are rejected before processing.

Condition Codes
Idaho Medicaid allows twenty-four (24) condition codes on an electronic HIPAA 837 Institutional claim.

Value, Occurrence, and Occurrence Span Codes
Idaho Medicaid allows twenty-four (24) value, twenty-four (24) occurrence, and twenty-four (24) occurrence span codes on the electronic HIPAA 837 Institutional claim.

Diagnosis Codes
Idaho Medicaid allows twenty-seven (27) diagnosis codes on the electronic HIPAA 837 Institutional claim.

Ambulance Services
Idaho requires the following information when submitting an electronic HIPAA 837 Institutional claim for ambulance services.

- Transport code
- Transport reason code
- Transport distance
- Condition code
- Round trip purpose when the transport code is equal to X for round trip

National Drug Code (NDC) Information with HCPCS and CPT Codes
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic Crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for institutional services.

3.1.3 Guidelines for Paper Claim Forms

3.1.3.1 How to Complete the Paper Claim Form

These instructions support the completion for the UB-04 Institutional billing claim form only. The following will speed claim processing:

- Provider numbers submitted on the paper UB-04 Institutional claim form must be the 9-digit Idaho Medicaid billing provider number (Field **51**); paper claims submitted with only the NPI will be returned to the provider; claims submitted with both the NPI and the Medicaid provider number will be processed using the Medicaid provider number only
- Complete all required areas of the UB institutional claim form
- Print legibly using black ink or use a typewriter
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning
- Keep claim form clean, use correction tape to cover errors

- A maximum of twenty-two (22) line items per claim can be accepted; if the number of services performed exceeds twenty-two (22) lines, prepare a new claim form and complete the required data elements; total each claim separately
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span
- Do not use staples or paperclips for attachments. Stack them behind the claim
- Do not fold the claim form(s), mail flat in a large envelope (recommend 9 x 12)

See *Section 3.1.3.3*, *Completing Specific Fields on a Paper Claim Form* for instructions on completing specific fields.

3.1.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.1.3.3 Completing Specific Fields on a Paper Claim Form

Refer to *Section 3.1.3.4, Sample Claim Form*, to see a sample UB-04 Institutional claim with all fields numbered. Provider questions regarding institutional policy and coverage requirements are referred to the *Rules Governing the Medical Assistance Program*.

The following numbered items correspond to the UB-04 Institutional claim form. Consult the 'Use' column to determine if information in any particular field is required and refer to the 'Description' column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

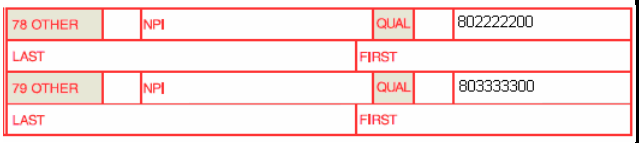
Field	Field Name	Use	Description
1	Unlabeled Field	Required	Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA). **Note:** If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.
3a	PAT. CNTL #	Desired	The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of patient financial records.
3b	MED REC #	Desired	Medical/Health Record Number: The number assigned to the participant's medical/health record.
4	TYPE OF BILL	Required	Type of Bill: Enter the 3-digit code from the *UB-04 manual*. Adjustment type-of-bill codes are not appropriate when submitting services on paper claim forms for Idaho Medicaid billings. See *Section 3.1.4*, *Type of Bill codes*.
6	STATEMENT COVERS PERIOD	Required	Statement Covers Period From/Through: The beginning and ending service dates of the period included on the bill. Enter as MMDDYY or MMDDCCYY **Administratively Necessary (AND):** The From date is the month, day, and year the participant was discharged from inpatient acute level of care. **Outpatient Claims**: Outpatient claims must indicate the specific dates in Field **45** to eliminate duplicate appearing services. **Late or Additional Charges:** **Inpatient** claims - see Field **42** for information. **Outpatient** claims - see Field **45** for information. **Accommodation Charges:** Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospital room occupancy when a participant is discharged under normal circumstances. Although there is no reimbursement for the discharge day; that date should always be entered on the claim form. This ensures that the hospital receives reimbursement for the last full day of accommodation. **Extended Hospitalization:** If a participant requires extended hospitalization and the hospital decides to send an interim claim, enter patient status code **30** in Field **17**. This code tells the system that the participant is still a patient and to reimburse the hospital for the last day on the claim. Example*:* Claims for three (3) sequential interim bills

Field	Field Name	Use	Description
			would have the following sequential date and patient status format: **Patient Days** **Claim From / To Date Status Billed** 1 01/15-01/31/04 30 17 2 02/01-02/15/04 30 15 3 02/16-02/24/04 01 8 **Note:** If patient status **30** is not used, the accommodation rate formula will not balance and the system will deny the claim.
8a	PATIENT NAME	Required	Patient Name: Enter the participant's last name exactly as it is spelled on the participant's Medicaid ID card.
8b	Unlabeled Field	Required	Patient Name: Enter the participant's first name exactly as it is spelled on the participant's Medicaid ID card.
14	ADMISSION-TYPE	Required, Inpatient	Admission Type: Use the priority admission codes in the *UB-04 manual*. Only codes **1**, **2**, **3**, and **4** are allowed by Medicaid. Required for inpatient claims.
15	ADMISSION-SRC	Required, Inpatient	Admission Source: Use the 1-digit source of admission codes **1** through **8** in the UB-04 manual. Medicaid does not accept code **9**. Required for inpatient claims. Not Required for outpatient claims.
16	DHR	Required, Inpatient	Discharge Hour: Enter the 2-digit hour the participant was discharged in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims. Desired for outpatient claims.
17	STAT	Required, Inpatient	Patient Status: Use one of the codes listed in *Section 3.1.5, Patient Status Codes*, to indicate patient status. Required for inpatient claims. Not Required for outpatient claims.
39-41	VALUE CODES AMOUNT	Required, AN Days	Value Codes and Amounts: See *Section 3.5, Billing Procedures*, for directions on how to bill AND. Covered Days: Required for inpatient claims only 80 – Covered Days 81 – Co-Insurance days (Cross over claims only) 82 – Lifetime Reserve Days (Cross over claims only
42	REV. CD.	Required, Inpatient	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. **Inpatient claims (late, additional, or denied charges):** 1. Late or additional charges where the revenue code was not on the original claim: Bill on a new claim for only the late or additional charges with the accommodation rate and revenue code**.** Note in the Field **80**, 'Billing for late charges.' 2. Late or additional charges where the revenue code was paid on the original claim: Submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: Bill the

Field	Field Name	Use	Description
			denied line with the accommodation rate and revenue code on a new claim. Note in the Field **80**, 'Billing for denied lines.' **Outpatient claims (late, additional, or denied charges):** For instructions for outpatients billing refer to Field **45**.
44	HCPCS / RATE / HIPPS CODE	Required, If Applicable	CPT/HCPCS/MODIFIERS/RATES: All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with **CPT** or HCPCS notation in *Section 3.5.5, Revenue Codes* and *Section 3.7.3, Ancillary Revenue Codes*. If the code requires a modifier, put one (1) space between the code and modifier. Example: PET scans require a HCPCS code and the **TC** modifier (i.e. G0222 TC). **Note:** HIPPS codes are not billable to Idaho Medicaid.
45	SERV. DATE	Required Outpatient	Service Dates: Required for all outpatient services. Enter the specific date of service for all charges or the claims will be denied. **Outpatient claims (late, additional, or denied charges):** 1. Late or additional charges outside the date span in Field **6**: bill on a new claim form. Note in the Field **80**, 'Billing for late charges.' 2. Late or additional charges within the date span in Field **6** with the same revenue codes and the same specific date: submit on an adjustment request form. 3. Late or additional charges within the date span in Field **6** with different revenue codes: bill on a new claim form. Note in the Field **80**, 'Billing for late charges.' 4. Resubmit all denied charges on a new claim.
46	SERV. UNITS	Required	Units of Service: Enter the total number of covered accommodation days or ancillary units of service. Units of service for accommodations must correlate accurately to the service rendered. Example***:*** Accommodation Code = Number of days the level of service was rendered. **Note:** It is important to put the most appropriate rate next to the related code. Do not average charges for the same code. If a participant in the hospital receives three (3) different levels of care, each must be billed on a separate line. Example***:*** Level I = $100 x 3 units of service Level II = $150 x 2 units of service Level III = $200 x 1 unit of service
47	TOTAL CHARGES	Required	Total charges: Bill total covered charges only. Ancillary Charges Formula: Revenue Code Fee X Units of Service Total Charges Accommodation Rate Formula: Daily Rate X Units of Service Total Charges

Field	Field Name	Use	Description
In Fields **50** through **62**, each field has three (3) lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one (1) other payer in addition to Medicaid, enter all primary payer date on line A and all Medicaid data on line B. If there are two (2) other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer date on line B, and all Medicaid data on line C.			
50 A	PAYER NAME	Not Required	Payer A: If Medicaid is the only payer, enter "Idaho Medicaid" in Field **50A**. If there is one (1) other payer in addition to Medicaid, enter the name of the group or plan in Field **50A** and enter 'Idaho Medicaid' in Field **50B**.
50 B	PAYER NAME	Not Required	Payer B: If there are two (2) other payers in addition to Medicaid, enter the names of the group or plan in Fields **50A** and **50B** and enter 'Idaho Medicaid' in Field **50C**.
50 C	PAYER NAME	Not Required	Payer C: If there are two (2) other payers in addition to Medicaid, enter 'Idaho Medicaid' in Field **50C**.
51 **A-C**	HEALTH PLAN ID	Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in Field **50 A-C**. Example: in Field **50A**, Medicare is entered as the Payer. In Field **51A**, enter the identification number used by Medicare for the provider. Example: in Field **50B**, Healthy Home Insurance Company is entered as the Payer. In Field **51B** enter the identification number used by Healthy Home Insurance Company for the provider.
54	PRIOR PAYMENTS	Required, If Applicable	Prior Payments - Payers and Participant: Required if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do not include previous Medicaid payments.
55	EST. AMOUNT DUE	Not Required	Estimated Amount Due: Total charges due (total from Field **47**) minus prior payments (total from Field **54**).
58	INSURED'S NAME	Desired	Insured's Name: If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's Medicaid ID card. Be sure to enter the last name first, followed by the first name, and middle initial. Enter the participant Medicaid data in the same line used to enter the Medicaid provider data. Example: Medicaid provider information is entered in **50a**, and then the Medicaid participant data must be entered in **58a**.
59	P. REL	Desired	Patient's Relationship to Insured: See the *UB-04 Manual* for the 2-digit relationship codes.
60	INSURED'S UNIQUE ID	Required	Participant Identification Number: Enter the 7-digit Medicaid ID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a 0 (zero) in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).

Field	Field Name	Use	Description
61	GROUP NAME	Not Required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	INSURANCE GROUP NO.	Not Required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORI-ZATION CODES	Required, If Applicable	Treatment Authorization Codes: Prior authorization (PA) number for AND, or retrospective reviews or PA number for ambulance run by EMS.
67	PRIN. DIAG. CD.	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. Do not use “E” diagnosis codes.
68-75	OTHER DIAG. CODES	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. Do **not** use “E” diagnosis codes.
69	ADM. DIAG. CD.	Required	Admitting Diagnosis Code: Required for inpatient. Desired for outpatient claims. Peer Review Organization (PRO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the *Qualis Provider Manual*.
72	ECI	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the CMS-1500 claim form for professional claims.)
74	PRINCIPAL PROCEDURE CODE / DATE	Desired	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical or obstetrical procedure. Procedure date is required if procedure code is used.
74 a-e	OTHER PROCEDURE CODE / DATE	Desired	Other Procedure Codes and Dates: Enter all secondary surgical or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
76	ATTENDING PHYS. ID	Required	Attending Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (last) box after ’76 Attending’ Inpatient: Enter the Idaho Medicaid provider number for the physician attending the patient. This is the physician primarily responsible for the care of the participant from the beginning of this hospitalization. Outpatient: Enter the Idaho Medicaid provider number for the physician referring the participant to the hospital.

78-79	OTHER PHYS. ID	Required, Healthy Connec-tion	Other Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (last) box of **78** or **79** 'Other' Required for Healthy Connections participants referred to the hospital by the primary care provider. Enter the primary care provider's 9-digit numerical referral number in Field **78** or **79**. Do not include the letters 'HC' before the number. If Field **78** is blank the information in Field **79** will populate the referral number field. 
80	REMARKS	Not Required	Remarks: Enter information when applicable. For participants who have only Medicare Part A, enter 'Participant has Part A only.' Other information to be entered may include: timely proof ICN, third party injury information, or no third party coverage.

3.1.3.4 Sample Paper Claim Form

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE _____ OF _____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.